BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF THE EATING PROBLEMS OF TWENTY-NINE CHILDREN REFERRED TO A CHILD GUIDANCE CLINIC

A Thesis

Submitted by

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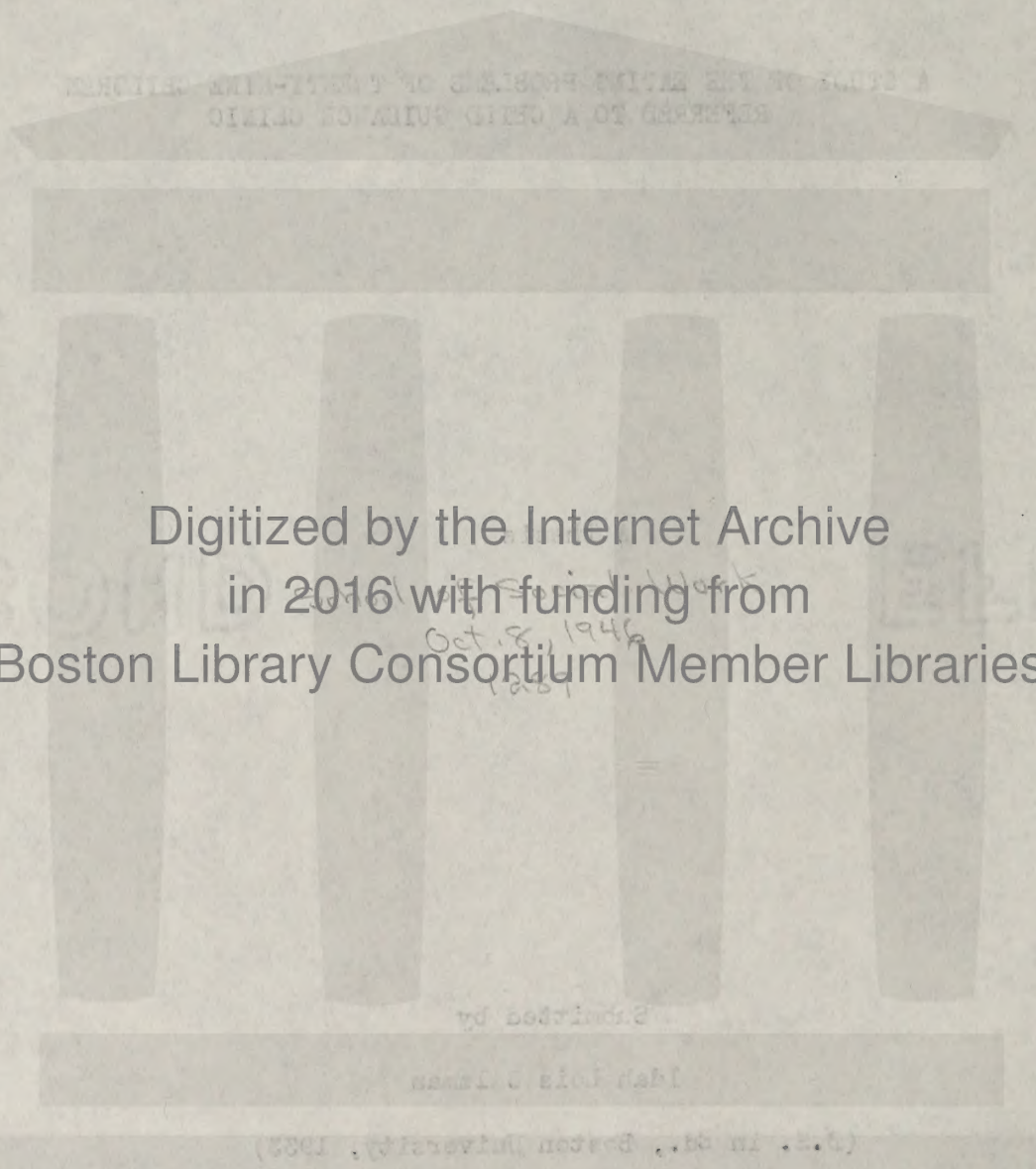

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CHAPTER I

INTRODUCTION

Purpose

Every year countless numbers of parents bring their children to Child Guidance Clinics because of some eating problem. The refusal of food and improper eating habits present serious biological as well as psychological manifestations. As a result of under-eating a child may be deprived of certain basic food elements necessary to his physiological growth. According to Selling, numerous studies have shown that lack of certain vitamins may specifically affect the personality of the child.[1]

In the cases referred to the Child Guidance Clinic because of an eating difficulty the more common complaints are poor appetite, food fussiness, vomiting, fears about food, finicky attitude and excessive appetite. Social workers and psychiatrists in these clinics are likely to ask why and how these difficulties arise. Is there an organic basis, is it because of the poor parent-child relationship, disturbed family situation, or, is it because of faulty habit training? In other words, why does the child choose this area to manifest abnormal behavior?

The purpose of this thesis is to study the causal factors involved in order to increase our understanding of the eating difficulties of children. This will include a study of the psychological and sociological factors as observed from the social service and psychiatric records used.

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Method and Scope

The twenty-nine cases used were taken from the files of the Child Guidance Clinics which are conducted by the Division of Mental Hygiene. A superficial survey revealed that in many instances the eating problem was not the primary factor, the data was too brief to warrant conclusions, or the child was not living with his or her parents. It was, therefore, decided to set up the following criteria as a basis for selection:

1. Cases in which the eating problem was the primary complaint.
2. Cases with full data which included the reports of the pyschiatrist, psychologist and social worker.
3. Cases in which the child was living within his own family group, with his own parents or at least his own mother.

In order to meet the above criteria it was necessary to select cases from the calendar years January 1, 1941 to December 31, 1944. The total number of cases referred during this period because of an eating problem was ninety-three. Twenty-nine were selected on the basis of the above criteria. Of the remaining sixty-four, thirty-four came for diagnostic service only; twenty-eight were short term contacts where full histories were not taken; and two mothers were not interested after the first interview. The following clinics are represented: Boston Dispensary, Brockton, Lowell, New England Hospital, Quincy and West End. Both the Boston Dispensary and New England Hospital Clinics are now closed.

With reference to research of this nature David Levy says:

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study of several thousand unselected cases. Our position is like that of a chemist who in first learning to analyze a metal picks out ores which, by common observation, obtain in the purest form the metal to be studied. After learning to analyze it, he is then able to isolate the metal from complex mixtures regardless of its quantity or combination with other agents.[2]

The type of study described above seems appropriate for this thesis. In formulating the schedule used the writer posed the following questions:

1. Of what significance is the child's age, sex, intelligence, ordinal position in the family?

2. What is his general health; is there a physical pattern among these children with eating problems that is significant?

3. What types of eating difficulties are manifested?

4. What does the eating difficulty mean to the child?

5. What are the personality traits of these children? Do the types of eating difficulties they exhibit fit into a larger pattern of characteristic relationships?

6. Is this behavior purposeful in the child's relationships with the mother?

7. Of what significance are the maternal attitudes towards pregnancy, breast feeding?

In the cases abstracted additional factors considered were those which would reveal in some detail the environmental setting of the problem.

The complete schedule used can be found in the appendix.

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CHAPTER II

MASSACHUSETTS CHILD GUIDANCE CLINICS: THEIR DEVELOPMENT AND FUNCTION[1]

The Massachusetts Child Guidance Clinics were established for the purpose of study and treatment of children manifesting patterns of behavior which interfere with their normal emotional development. These clinics also offer a diagnostic service and assistance with problems of child training and personality development. Their objective is to prevent emotional disorders by early recognition of unfavorable habits and behavior.

Child Guidance is essentially an outgrowth of modern psychiatry and mental hygiene. The movement originated with clinics established to serve juvenile courts, but it was not long before the advisability of extending such services to the entire community was recognized.

In 1919 the General Court of Massachusetts passed a law making the examination of all school children who were three years retarded obligatory and requiring the establishment of special classes where there were ten or more of such children found.[2] Traveling school clinics were established throughout the state and schools for the feebleminded and state hospitals provided the examinations. These clinics, although under suspicion at first by school boards, soon proved their worth and by 1920 a number of them were well established throughout the state

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servicing adults as well as children.

The Child Guidance movement grew by leaps and bounds so that in 1922 the Massachusetts Legislature established a Division of Mental Hygiene under the Department of Mental Health.[3] Dr. Douglas A. Thom, an outstanding leader in the Child Guidance movement was appointed director. In 1921 Dr. Thom had, at the request of the Baby Hygiene Association, conducted a survey which resulted in the establishment of so-called habit clinics. These clinics were probably the first of their kind to offer psychiatric therapy for very young children. Three of these clinics were established under the auspices of the Community Health Association.

Massachusetts was among the first of the states to furnish funds for the establishment of Child Guidance Clinics. These were to be set up for experimental and demonstration purposes first and after six months were to be absorbed by other community resources such as hospitals and private organizations.

Between 1923 and 1924 eight clinics were established. All were later taken over by other agencies except the West End Clinic which is still servicing Boston and its environs.

The Massachusetts Society for Mental Hygiene, through its educational work, gave the movement impetus which resulted in a period of expansion from 1924 to 1938. During this time clinics were opened at the Boston Dispensary, Lynn, Beverly, Springfield, Lowell, Reading, Worcester and Quincy. Some of these were later absorbed by state

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3 Acts of 1922. Chapter 519

[illegible]

hospitals as in the cases of Lynn and Beverly which were taken over by Danvers State Hospital and Springfield which was supervised by the Monson State Hospital. The Boston Dispensary Clinic became a part of the Children's Department of the hospital.

The trend in the Child Guidance movement in Massachusetts fell into two categories. Community clinics, whose referrals were mostly from schools, social agencies and the community at large; and, hospital clinics, those connected with hospitals. Although the medical clinics had the advantage of medical services whenever needed, and also served as an opportunity for instruction of medical internes and student nurses in the recognition and treatment of neurotic symptoms, the community clinics served as a means of interpreting the work of the clinics. During this period special services such as speech therapy, remedial reading and occupational therapy were offered in these clinics. Also, about December, 1937 the name was changed from Habit Clinic to Child Guidance Clinic as it was felt that the term "habit clinic" referred to the pre-school child and the clinics were now dealing with children up to fourteen years of age.

The period from 1933 to 1943 was one of stabilization rather than of expansion, except for one clinic established in Brockton with the cooperation of the school department which provided housing and a clerical staff.

Although several clinics were closed during the early years of World War II because of a shortage of personnel and transportation difficulties, a different type of clinic was opened in 1943, the Southard Clinic housed at the Boston Psychopathic Hospital. Personnel was obtained from

three clinics that were closed at that time. Although the Division of Mental Hygiene had been clamoring for this type of clinic for a number of years because of the many advantages connected with it, the disadvantage lies in the fact that parents very often hesitate to bring their children to a clinic housed in a psychopathic hospital. In addition to the Southard staff the Division staff held five sessions[4] weekly, then reduced them to four. The demand for these services in the Division clinics outside of Boston became so great that the Division was forced to withdraw their staff from Southard Clinic in February 1945 in order to meet this need.

At the present time there are six clinics operating under the Division of Mental Hygiene. Of these, four are directly connected with the Boston office. These are Brockton, Lowell, Quincy and West End. The Lowell Clinic is housed in the Lowell General Hospital and holds only one session weekly. The West End Clinic is housed in a Health Center and also holds only one session weekly. Both carry large case loads which place a tremendous burden on the psychiatrist and social worker. Because of this tremendous pressure of numbers intensive therapy is impossible. Both clinics offer speech therapy and tutoring.

The Brockton and Quincy clinics present an entirely different set up. The Quincy clinic was first opened in 1926 and was conducted at the Quincy Dispensary until 1931 when it was moved to the Woodward School where it remained until 1943 at which time it was moved to the Children's Health Center. This clinic differs from the others in its physical and

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financial set-up and serves as a model clinic for the entire state. It is an example of what a community can do in cooperation with a state organization. The Children's Health Center, where the clinic is now housed, was formerly a private home, lent by the library which owns the building. The Quincy Guidance Association, a community organization which has been active in establishing this clinic, has provided the furnishings and raises funds to enlarge the program. Remedial reading, speech therapy and occupational therapy are offered to children who need it. This clinic has four sessions weekly and is staffed by two psychiatrists and two social workers.

The Brockton clinic set-up is quite different. There the schools have cooperated with the Division of Mental Hygiene and established a clinic in a suite of offices in the School Department building. The value of this type of clinic was quickly recognized so that now there are four sessions weekly. Special services such as speech correction and remedial reading are offered. The clinic also supervises the special classes for superior children which are in operation in the Brockton school system. This clinic is also fortunate in that all the local social agencies work in close sooperation with it. This clinic is served by one psychiatrist and one social worker.

Application for clinic services come from various sources including physicians, parents, schools, social agencies, hospitals, courts and the general public. The Child Guidance Clinics in Massachusetts service only normal children and the age limit is fourteen although there is an exception to this rule occasionally. This is especially true in

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Brockton and Quincy where there is such close cooperation between the schools and clinic.

The professional team of psychiatrist, psychologist and social worker has been functioning effectively since 1920. The psychiatrist sets the pace and controls treatment.

The usual routine is for the mother or some other adult to bring the child to clinic at an appointed hour and, after the intake interview, the child is seen by the psychologist who administers the psychological tests. Special tests are given if the psychiatrist deems it necessary. The results are given to the psychiatrist who then talks with the mother. The psychiatrist interprets the results of these tests to the mother and also obtains a developmental history of the child as well as a history and pertinent factors of the problem involved. The psychiatrist then sees the child and makes a tentative diagnosis. Also at this time the psychiatrist decides whether the case will be accepted for treatment. Environmental manipulation and obtaining the social history is the job of the social worker. After all this information is gathered and studied the psychiatrist then decides whether she will work with the mother or the child. In most cases the psychiatrist works with the child and the social worker with the mother. On rare occasions, however, it is the other way around. Either way the social worker is under the direction of the psychiatrist.

At the present time the Division of Mental Hygiene staff consists of a director, one full-time and two part-time psychiatrists, one full-time and three part-time psychologists, one head social worker and five

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CHAPTER III

BACKGROUND OF GROUP STUDIED

The Children

Before embarking on a study of the eating problems of these twenty-nine children the writer feels some descriptive background material is necessary. This will include age, sex, ordinal position in the family, intelligence, religion, nationality, and school grade.

In the group studied, there are fifteen boys and fourteen girls. By pure coincidence the group is practically evenly divided and the writer does not attach any significance to this, except to say that eating difficulties are prevalent among boys and girls.

TABLE I

AGE DISTRIBUTION

Age	No.
Under 2	1
Under 4	13
Under 6	6
Under 8	5
Under 10	3
Under 12	1
Total	29

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Ages at time of referral range from sixteen months to eleven years. By far the largest group, or more than one-half, are of pre-school age indicating that eating difficulties are more prevalent among very young children. Eleven are between six and eight years and four between ten and twelve years. The children in the latter group had not outgrown or learned to control their eating habits at an age when the average child has passed through the oral stage of his development.

Sixteen of the twenty-nine children studied are pre-school, two are in the kindergarten, six in the first grade, one in the second grade, two in the third grade, one in the fifth and one child is in a special class, a combination of the second and third grades. School placement of these children is approximately normal for their chronological age.

There are eleven only children. Of the remaining group, six are first-born and four are the youngest. Of this group the six first-born are the oldest of two siblings, one is the youngest of three, and three are the youngest of two. In addition, there are three cases where the child is the middle of three siblings, two where the child is the third of three. Finally, there are two children who are the third of four and one who is the seventh of nine. Ordinal position has some importance in the genesis of the child's eating difficulty. In individual family situations sibling rivalry was an important factor. Often times the first-born felt rejected when the second child entered the home and was the object of the mother's attention. On the other hand, in some cases the child felt the elder sibling was favored by the mother.

TABLE II

DISTRIBUTION OF INTELLIGENCE QUOTIENTS

Intelligence Quotient	No.
80-89	5
90-109	14
110-119	1
120-129	3
Not stated	6
Total	29

The Stanford-Binet, which is the basis for the above intelligence quotients, is administered by the clinic psychologist. Of the group tested, about one-half is of average intelligence, four are in the superior group, and five are dull-normal. The remaining six could not be tested for one reason or another. As the reader will see later, high intelligence did not prevent the occurrence of scholastic difficulties and behavior problems in school in individual cases. It is merely indicative of the intellectual level of the children studied. At this point it will suffice to say that when scholastic difficulties did arise they were not due primarily to low intelligence.

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TABLE III

RELIGIOUS DISTRIBUTION

Religion	No.
Greek Orthodox	1
Jewish	7
Protestant	5
Roman Catholic	10
Unknown	3
Mixed Marriage	3
Total	29

The writer does not attach any significance to the fact that the largest group represented is Roman Catholic and feels that it is pure coincidence. Of the mixed marriages, in one case the father is Roman Catholic and the mother is Congregationalist; in the other two, the fathers are of Protestant faith and the mothers are Roman Catholic. What effect these mixed marriages have on the emotional development of the child is difficult to say because of the lack of factual material in the case histories studied.

The Parents

In order to better understand the personalities and relationships within the family groups of these twenty-nine children the reader should be aware of certain descriptive factors about the parents and the homes.

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There is a variety of nationalities represented in this study group. The largest group number seven and are of Russian origin. Interestingly enough this group is also Jewish. There are four each of American, Italian, and Irish background, two English and one each of Armenian, Greek, Polish and Portuguese origin. There are four where the nationalities are unknown.

On the whole, the parents of this group are fairly well educated. Approximately one-half completed grammar school, a large group are high school graduates, three fathers and two mothers attended some specialized school and one father holds a Master of Arts degree.

The occupations of the fathers are varied. They are salesmen of one kind or another, skilled workmen, factory workers, merchants, unskilled laborers, two formerly on WPA, one is a successful advertising executive and one an electrical engineer. The father who holds the M.A. and wished to teach was working as a clerk at the time of the child's referral. All the mothers are housewives except for two, one of whom is a successful interior decorator and the other a waitress. Before their marriage these women worked as saleswomen, factory workers, domestics or office workers. After marriage their only concern was their home and

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family.

Of the twenty-nine children studied, seven came from a compound household; that is, another person was living within the immediate family group. The immediate family group includes only the mother, father and siblings. In two cases the paternal grandparents were living in the home, there was one in which the paternal grandmother was in the home, and one where the maternal grandmother made her home with the family. In one case the paternal grandfather lived within the family group and another maternal grandfather and two maternal aunts lived with the family. Lastly, there was one case where several maternal aunts and uncles lived in the home. These persons may sometimes be a disturbing element in the household. There were five cases where one member of the family was absent. In one, the father died four months before the child was born, in another the father died one year before the child was brought to clinic. There was one where the father was in the service and another where the father deserted from time to time and was not living in the home at the time of referral. In the fifth case two older siblings were living out of the home. More than one-third of the twenty-nine cases gave evidence of a disturbed family group. Since the family is the most important influential factor in developing personality traits, the effects of these disturbances will show in this study. The absence of the father from the home also affects the adjustment of the child and interferes with parental identifications.

This study group represents a good cross-section of the middle class. The economic status of the home as described, represents the social

family.

Of the twenty-nine children studied, seven came from a compound household; that is, another person was living within the immediate family group. The immediate family group includes only the mother, father and siblings. In two cases the paternal grandparents were living in the home, there was one in which the paternal grandmother was in the home, and one where the maternal grandmother made her home with the family. In one case the paternal grandfather lived within the family group and another maternal grandfather and two maternal aunts lived with the family. Lastly, there was one case where several maternal aunts and uncles lived in the home. These persons may sometimes be a disturbing element in the household. There were five cases where one member of the family was absent. In one, the father died four months before the child was born, in another the father died one year before the child was brought to clinic. There was one where the father was in the service and another where the father deserted from time to time and was not living in the home at the time of referral. In the fifth case two older siblings were living out of the home. More than one-third of the twenty-nine cases gave evidence of a disturbed family group. Since the family is the most important influential factor in developing personality traits, the effects of these disturbances will show in this study. The absence of the father from the home also affects the adjustment of the child and interferes with parental identifications.

This study group represents a good cross-section of the middle class. The economic status of the home as described, represents the social

worker's judgment in each case. Two are in the high income brackets, fourteen were considered to be in comfortable circumstances, seven had a moderate income and six were living on a marginal income.

The sources of referral indicate that in the majority of cases the mothers felt that the child's eating difficulty was of physical origin as seven were referred by local physicians, nine by the Children's Clinic of the Boston Dispensary, one by the Children's Hospital and three by the New England Hospital. Other referrals were from such sources as the Family Society, the Well Baby Clinic, the Visiting Nurses Association, a school principal. Only two came from the mothers themselves and one was referred by the paternal grandmother.

CHAPTER IV

BEHAVIOR AND PERSONALITY PROBLEMS

Before discussing the eating difficulties of these children an examination of their personality and behavior problems is essential in order to contribute to the understanding of how these disturbances in the eating area are a part of the child's attempt to adjust to the demands of his person and environment.

> It is impossible to think of the eating problem of children as disassociated from their total personality configurations. Those who have studied the medical and psychiatric implications of eating disturbances have stressed that, although the need for food has an original physiological basis, it becomes intimately related with psychological factors and may assume symbolic significance which has no primary relation to the problem of survival.[1]

An attempt has been made to group the outstanding characteristics of the children's personalities into three categories: those who were generally aggressive, with some who were aggressive only at home within their own family group; those who manifested generally passive behavior, and finally, those whose behavior was considered normal. In many instances these terms were used by the psychiatrist in the diagnosis. Some overlapping occurs since each group includes characteristics of the other groups. The following are descriptions of these three groups based on the cases studied:

NORMAL: When given the opportunity these children were able to form

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friendships, they assumed responsibilities and independence in accordance with their age levels, and they had the usual interests commensurate with their age. This is not to say that these children did not manifest abnormal behavior at one time or another. However, judging from the degree of this abnormal behavior they were considered to be normal. In these cases the conflict centered around food and was considered a normal reaction to extreme parental attitudes or faulty training.

PASSIVE: These children displayed negativism, were sensitive, submissive, lethargic. They cried easily, were jealous of siblings, were considered "nervous".[2] They were always on the defensive and never by an overt action against others attempted to satisfy their own needs or desires. They had few playmates and bent over backwards seeking approval. In many instances psychiatric interviews revealed these children harbored feelings of anxiety, inferiority and hostility which were seldom overtly expressed making them even more miserable than those who openly displayed their feelings in their relationships with others.

AGGRESSIVE: These children were more positive in their behavior. They overtly displayed anger by physical and emotional outbursts. When not given their own way they resorted to temper tantrums, they demanded attention, they could not get along with other children as they tended to dominate and disregard the rights of others. They were disobedient and defiant, jealous of siblings and some were negativistic in their reactions. Those who were aggressive in their home only displayed these characteristics towards members of their family group.

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2 Term used by psychiatrist

Of the twenty-nine children studied, ten were generally aggressive, five displayed agression within their own family, nine were considered passive, and five were said to be normal. Since the children in the aggressive and passive group manifested emotional disturbances throughout their personalities and not merely in their eating habits, the terms agressive and passive do not wholly express the degree of maladjustment.

The agressive child should not be considered the more maladjusted. Because of his overt actions his abnormal behavior is more discernible, whereas, the passive child does not get into distinct problem situations, but rather withdraws and attempts to gain the satisfaction and love of others by permitting them to control the situation.

These children exhibited a variety of behavior and personality problems in addition to the eating difficulty.

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TABLE IV

ADDITIONAL PROBLEMS REVEALED

Problem	No. of children
Neurotic habits or symptoms	
Finger nail biting	6
Enuresis	5
Speech defects	4
Thumbsucking	2
Tics	2
Lip biting	1
General Personality Problems	
Inability to get along with others	12
Jealousy of siblings	8
Attention getting behavior	7
Temper tantrums	6
Stubbornness	6
Disobedience	6
Negativism	6
Hypersensitivity	5
Immaturity	5
Day dreaming	4
Poor school work	3
Refusal to go to school	3
Night terrors	2
Vomiting	2
Protective lying	2
Fears	2

Symptoms such as enuresis, tics and fears indicate severe emotional difficulties. Fingernail biting, lip biting, thumb sucking and speech defects are neurotic symptoms of an oral nature and correlate with the eating difficulty. The two largest symptoms under general personality problems suggest disturbances in the sphere of social adaptation and reverts back to the inter-relationships within the home, probably between mother and child. Table IV clearly indicates that in the majority of cases the eating problem was accompanied by other personality

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Tics	3
Lip biting	1
General Personality Problems	
Inability to get along with others	12
Jealousy of siblings	8
Attention getting behavior	7
Temper tantrums	6
Stubbornness	6
Disobedience	6
Negativism	6
Hyperexcitability	5
Immaturity	5
Day dreaming	4
Poor school work	3
Refusal to go to school	3
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difficulties. These problems represent the usual variety of difficulties encountered in a child guidance clinic.

TABLE V

PROBLEMS CORRELATED WITH THEIR PERSONALITY TYPES

Problem	No.	No.	No.
Neurotic Symptons	Aggressive	Passive	Normal
Enuresis	4	1	
Thumbsucking	1	1	
Fingernail biting	3	1	2
Speech difficulties		4	
Tics		2	
Lip biting		1	
General Personality Problems			
Temper tantrums	5	1	
Immaturity	1	3	1
Inability to get along with others	8	4	
Attention getting behavior	5	2	
Jealous of siblings	5	3	
Day dreaming		3	1
Protective lying	1	1	
Fears	1	1	
Stubbornness	4	2	
Disobedience	3	3	
Poor school work	1	1	1
Refusal to go to school	2	1	
Night terrors	2		
Negativism	1	4	
Vomiting		1	1
Hypersensitivity		5	2

An attempt at a solution of a conflict in childhood manifests itself in problem behavior. The resultant symptoms depend upon the causative factors within the child's environment. A child may attempt to solve his conflict in a variety of ways. Whether his behavior is aggressive or passive it has the same meaning to him for it is his way of express-

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Finger-nail biting	3	1	2
Speech difficulties		4	
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Lip biting		1	
General Personality Problems			
Temper tantrums	5	1	
Immaturity	1	3	1
Inability to get along with others	3	4	
Attention getting behavior	3	2	
Jealous of siblings	5	3	
Day dreaming		3	1
Protective lying	1	1	
Fears	1	1	
Stubbornness	4	2	
Disobedience	3	3	
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Night terrors	2		
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Vomiting		1	1
Hyperexcitability		3	2

An attempt at a solution of a conflict in childhood manifests itself in problem behavior. The resultant symptoms depend upon the causative factors within the child's environment. A child may attempt to solve his conflict in a variety of ways. Whether his behavior is aggressive or passive it has the same meaning to him for it is his way of expres-

ing his feelings towards his environment. Either group indicates that the children felt insecure to a certain degree. As can be seen from Table V not only did each child have numerous symptoms but in many cases overlapped so that many symptoms were evident to some degree in all groups.

CHAPTER V

EATING PROBLEMS

A great proportion of eating problems develop in the first two years of a child's life. These problems arise for a number of reasons. In a great many cases it may be due to the mother's anxiety. It is true that the overprotecting mother is apt to have more concern about food intake. However, the fairly stable mother also encounters eating difficulties of one kind or another. So much stress has been placed on nutrition and dietetics, much of it arbitrary, through the radio, magazines, newspaper advertisements and physicians that many mothers are bewildered. The accent has been on food intake and nutritional values and little has been said about the psychological aspects of feeding.

Eating is one of the first pleasurable sensations a young child experiences. Lurie has pointed out the importance of early feeding satisfaction in the development of the individual's emotional security and the psychological equation of food and love.[1]

Psychiatrists place importance upon the first eating experiences of the child. For example, the will to eat is a natural instinct and one does not have to learn the act of eating. However, food attitudes, tastes and habits are acquired through experience. If a child cries for reasons other than hunger and is given food as a means of quieting him, he may develop a dislike of food because of its association with unpleasant situations. Likewise, when a mother rushes serving of meals the

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child may acquire a dislike for food; also, too many diversions at mealtime develop a slow and lingering attitude which may prove annoying and undesirable in later years.

Some children develop eating difficulties immediately they are born. Psychoanalytic thinking stresses the importance of the early relationship between the child and its mother. A baby taking milk from his mother's breast not only satisfies his hunger but experiences his first physical pleasure. The child is dependent upon his mother for his physical and psychological gratifications. The pleasure gained in emotionally healthful eating experiences contribute toward the wholesome physical growth and emotional development of the child.

The mother then is the key to the emotional development of the child as a result of the role she plays in the fulfillment or frustration of the child's instinctual drives. Of great import is the mother's attitude toward the child. If there is a healthy relationship and the mother not only satisfies the child's physical needs but gives him the feeling of security and acceptance he craves he will develop into a self reliant and independent individual. Ribble emphasizes that infants are in need of a feeling of security for a normal healthy development. This feeling of security is induced by the mother's display of affection and warmth toward the baby in her physical contact with it such as in the way she touches or caresses it, and points out that babies have a keen sensitivity and can feel whether they are wanted or not.[2]

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> The overprotective parent seizes upon food disturbances whether it be due to habit or some other cause, as a means of taking care of his own emotional needs. The parent is not aware of the effect this has upon the child, nor the consequent behavior difficulty which may extend way beyond the field of eating.[3]

About one-third of the children studied were breast-fed for at least one month. In the majority of cases, however, the children had been changed to bottle feeding by the time they reached the age of two months. Reasons given by mothers for changing to bottle feeding varied. Some said they had insufficient milk, others felt the child was old enough to use a bottle, still others expressed a dislike for breast feeding, several mothers were ill and could not nurse the child and some offered no reason for ceasing breast feeding. The importance of breast feeding cannot be minimized. It is the most important and satisfying type of infant feeding. It is during this period that the child gains his first oral and emotional satisfactions. Denial of these satisfactions may lead to serious personality difficulties later on.

In most of the cases studied the eating difficulties were not suddenly acquired. Many displayed eating difficulties of various degrees of severity during the weaning period and the introduction of solid food.

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> The shift from breast to bottle is a crisis. The introduction of the first food other than milk, the first presentation of solid food, each new flavor, each new consistency, may be and often is a crisis.[4]

The development of eating problems usually begin at the age of one, during the weaning period. More than one-half of the children studied were weaned from the bottle at the age of one. Their reactions varied. Some refused to take food and were forced to eat, a number cried, were finicky and fussy, another group gagged and vomited, a fourth group, although they accepted the food after numerous coaxings resorted to thumbsucking, there were a number who accepted the change without any overt display of dissatisfaction, and finally one child weaned herself by refusing the breast. In such a case as this Hill attributes this to reactions to maternal stress or unwholesome attitudes on the part of the mother.[5]

At about this age the amount of food intake decreases and the child begins to exercise his own will in attempting to select what he will eat. The mother is unprepared for this and is determined that the child shall consume the amount and whatever she gives him. This results in a contest of wills and a continuing bearing down on him sets up a conflict.

> To some mothers the child's mealtime is of consuming importance. It is the chief worry of their lives... Without question the child feels this concern, feels his power in having caused it, enjoys the attention

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In all cases, however, except where the eating difficulty was due to faulty training, it is quite evident that the child, either at the very beginning or at some time when he felt his security threatened, seized upon the eating area to express his dissatisfaction.

The eating problems of these children were characterized by eleven different types of behavior toward food. Most of them exhibited several types of reactions. Table VI below indicates how frequently they occur in the group as a whole. Some refused solids, others would not eat meat or fish. Many children refused to eat vegetables of one kind or another, and some refused to eat the food mother served unless prepared in a particular way. While some objected to milk others preferred milk to any other food. At any rate these children showed great variance in their food aversions.

TABLE VI

REACTIONS TOWARD FOOD

Reaction	No.
Dawdling	16
Will eat only certain foods	15
Refusal of food	12
Will not eat solids	12
Finicky attitude	11
Will eat only strained foods	10
Poor appetite	10
Vomiting	8
Gags	6
Fears about food	2
Nausea without vomiting	2

6 Elliot, Op. cit., P. 403

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In all cases, however, except where the eating difficulty was due to family training, it is quite evident that the child, either at the very beginning or at some time when he felt his security threatened, reacted upon the eating area to express his dissatisfaction.

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The personality of the child was not a determinant factor in the pattern of the eating behavior. There was a similarity of reactions to food among the aggressive, passive and normal children.

The types of reactions mentioned in Table VI all have an aggressive quality. Special likes and dislikes, a finicky attitude and dawdling are forms of self assertion and have a mild aggressive quality. When a child refuses to eat what is served him and demands something else or, if he refuses to eat as fast as his mother wants him to he is attempting to control the situation or, better still, dominate the mother, and is showing his defiance of her by refusing to eat or not eating as quickly as she desires. Vomiting, refusal of food and nausea without vomiting are negativistic reactions to food. These are other ways of protesting against food and are also a means of gaining the upper hand in the eating situation. A good many children who are unable to obtain the recognition they seek through normal channels seize upon the eating area as a means of having their own way. They can also maintain their dependency by refusing to eat unless fed by mother. Lurie, in her study, concluded that eating disturbances may be a protection of the child's dependent status by compelling mother to administer to his needs, or revenge upon mother for past or present deprivations, or self-denial to assuage the guilt which arises from aggression toward the mother who frustrated the child's demands for her affection.[7]

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purely aggressive or purely passive. Neither does the normal child always react in a normal manner. Rather each personality has within it the means of reacting in an aggressive or passive manner. The aggressive children were at odds with their families and the outside world at all times and their eating behavior was not considered unusual in the light of their total behavior. They were brought to clinic because of the anxiety of the mother. The passive child used the eating area as an outlet for aggression which he repressed in his contacts with his family and friends. As with the normal children their abnormal eating behavior was more discernible. The general consensus is that eating problems in children usually connote aggressive reaction.

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CHAPTER VI

CLASSIFICATION OF CASE STUDIES

The cases to be presented have been grouped into two divisions. Within these divisions, however, the causal factors interwine and there is some overlapping. In general, the cases studied fall into two groups, those where for the most part the eating difficulty is due to:

1. Maternal approaches toward feeding.
2. Poor home conditions and poor relationships which would include:
   a. Marital discord
   b. Ineffectuality of parents
   c. Interference of relatives
   d. Rejection
   e. Overprotection and overindulgence
   f. Sibling rivalry

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CHAPTER VII

CASE PRESENTATIONS

Maternal Approach Toward Feeding

Case 1. ARTHUR

Arthur was referred by a hospital physician at the age of five because of food fussiness and vomiting. He refuses to eat solids and mother must strain all foods and grind meats. He will spit out any food that is not finely ground. He makes a great deal of fuss about eating and is worried about what is on the menu. When he doesn't like the food he vomits. He has vomited at every meal for the past two years. He complains of feeling sick after eating. Mother has been in the habit of feeding Arthur immediately after he vomits. Mother coaxes, nags and forces him to eat. She amuses him while he dawdles with his food. She has never permitted him to feed himself because "he just won't eat if I do". At time of referral Arthur would eat nothing but orange juice, soup, milk and egg.

Arthur also bites his nails to the quick, has temper tantrums and sucks his thumb. He cannot get along with other children because he is bossy and refuses to share his toys. When Arthur wants something he will promise to eat. Both parents have always given in to him. With considerable feeling mother told worker, "I guess I was not intended to bring up children".

Mother had a difficult pregnancy as she suffered with nausea during the entire time. She was ill for a long period after child's birth and was unable to breast feed him. He was bottle fed and never derived any satisfaction from eating. He would cry and never finish the bottle. At five months he was spoon fed.

This is a compound household, family living with paternal grandparents who indulge Arthur and interfere with discipline. Father pampers Arthur and spends a good deal of time with him. Father, formerly on W.P.A., is a World War I veteran with a discharge of psychoneurosis, hysteria. His general attitude was described as "decidedly puerile". Mother expressed dissatisfaction with her marriage as she finds the routine of housework dull and wishes there was some way she could work instead of staying home. She was evasive in discussing relationship with father. Parents have no social life.

CHAPTER VII

CASE PRESENTATIONS

Maternal Approach Toward Feeding

Case 1. ARTHUR

Arthur was referred by a hospital physician at the age of five because of food fussiness and vomiting. He refuses to eat solids and mother must strain all foods and grind meats. He will spit out any food that is not finely ground. He makes a great deal of fuss about eating and is worried about what is on the menu. When he doesn't like the food he vomits. He has vomited at every meal for the past two years. He complains of feeling sick after eating. Mother has been in the habit of feeding Arthur immediately after he vomits. Mother coaxes, begs and forces him to eat. She amuses him while he dawdles with his food. She has never permitted him to feed himself because "he just won't eat if I do". At time of referral Arthur would eat nothing but orange juice, soup, milk and egg.

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> Mother and Arthur were seen for seven months at which time mother was able to accept some interpretation. However she was unable to follow through on some of the suggestions such as being firm in discipline, not giving in to his every whim, and permitting Arthur to eat by himself. Arthur also refused to come to clinic and at one time told worker if she wanted to see him she could come to his house.

From the very first life has revolved around Arthur who has sensed mother's oversolicitude about his eating and has seized upon it to dominate her. Mother's overprotection and indulgence is indicative of compensation for unconscious rejection. Her hostility is expressed in the agressive manner in which she feeds him. Arthur feels this hostility and is reacting in a like manner by vomiting. His thumbsucking is no doubt due to lack of oral satisfaction. Nail biting is a neurotic symptom due to some deep seated conflict. Arthur is regressing to infantile behavior and wishes to remain dependent on mother when he refuses to eat solid food.

Grandparents, who in all probability were reluctant to give up their son, are by indulgence, attempting to capture their grandson. Father, an ineffectual individual, with a diagnosis of psychoneurosis, hysteria, is probably involved in many conflicts of his own and is unable to give Arthur the security he needs. There is some jealousy on mother's part because father spends so much time with Arthur.

Mother's fear of Arthur's not eating and becoming ill when she feeds him after vomiting may be a compensation for an aggressive wish.

Arthur is using the eating area as a means of gaining attention and this represents some aggression on his part.

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Case 2. BETTY

Betty, an only child, was referred to the clinic by a physician at the age of eighteen months because she refused to eat. She holds food in her mouth and refuses to swallow it. According to mother she has always been a feeding problem. Mother has forced food into her by holding her mouth open, by coaxing and cajoling. When mother tries to feed Betty she pushes mother's hand away or she puts her hand on her mouth and draws her head away. When mother is not feeding her she is constantly putting out her hand for food but will not eat it when given. When given a spoon she dabbles with the food and throws it on the floor, but if mother leaves the room she will eat while mother is gone. Will drink milk from a bottle only and if lying down. According to mother Betty "would be a perfect baby" if she would only eat. Betty also sucks the sheet, bites her nails and wets occasionally.

Mother was ill and not happy during pregnancy. She was bitterly disappointed as she did not want a child so soon after marriage. Parents were secretly married and because of the pregnancy were forced to reveal the marriage. Betty was breast-fed for three months and mother has not been able to wean her from the bottle.

Father, a university graduate, wanted to be a teacher but is now working as a clerk. Mother, when working, earned more money than father. Mother was the youngest of many children and always spoiled and petted. She is the favorite of a maternal uncle who has showered her and Betty with gifts. Father is jealous of this relationship. Mother dislikes duties as a wife and mother and said to worker she "would rather be back in an office". Mother fears for child's physical health and has taken her to several doctors for advice as she is afraid Betty will become ill if she doesn't eat.

Treatment lasted for eleven months during which time mother was given suggestions as to how to deal with Betty. She was spasmodic about following through and was unable to starve Betty for a day as suggested by the psychiatrist. Mother seemed to think new recipes as suggested by the clinic would affect a cure. During this time mother confided in worker that father wanted another child but she was not ready for another. When case was closed Betty had improved somewhat.

This child arrived at a most inopportune time when mother was employed and did not want to give up her job. Mother is rejecting her duties as a wife and mother and is displacing this rejection onto the child. Mother

shows her unconscious rejection of Betty in being overprotective. She fears her own aggressive wishes and shows guilt in her inability to follow through with the psychiatrist's recommendation to starve the child for a day. She shows her aggression towards Betty in her method of feeding which is punishing.

Wetting is not a serious problem at that age but Betty also sucks the sheet and bites her nails which are symptoms of lack of satisfaction and security. Betty is a willful youngster determined to maintain her position of domination. In her refusal to take food from her mother she is using the feeding situation as a means of expressing aggression toward mother and a wish to remain a baby.

No doubt there is marital disharmony which would add to Betty's insecurity but information is lacking.

Case 3 JANET

> Janet, age four, is the older of two siblings, the younger a boy, age six months. Mother always fed Janet because she dawdled and would play with food. She will not eat butter, milk or meat. The only vegetable she eats is potato. Mother has forced her to eat by punishing her, she ties her to the chair so she cannot get up and sometimes mother promises her some delicacy if she finishes the plate. When forced to eat Janet holds her breath until she becomes cyanotic. At first mother thought these were convulsions.
>
> Janet ate well while staying with an aunt during mother's confinement and she presents no problem at the nursery school. Janet gets along well with other children. In talking with worker, mother remarked that Janet is driving her mad because of her eating habits as she must spend so much time with her. Janet refuses to go to bed without mother.
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Mother has always been afraid something will happen to Janet ever since she was born. Until she entered school, which is a few doors away from home, Janet was not permitted to play with other children, except a cousin as mother was

afraid Janet would "catch a germ". Janet got along well with this cousin until sibling was born when she began to show resentment because of the attention shown him by this cousin. She has also become extremely cranky and fretful whenever mother does something for sibling and also demands something of mother at the same time.

Mother was well during pregnancy but when told it was to be a Caesarian birth became very unhappy as she feared she would die. She literally starved herself in order to have a small baby. Janet was breast fed for three months when she suddenly refused to take the breast. She has been a feeding problem since. Janet was never disciplined and had her own way most of the time. She was also the center of attraction among relatives until the arrival of the new baby. At this time mother's attitude toward Janet changed. She became extremely severe, punishing her at times without cause. Janet is annoyed and unhappy when sibling is picked up and wants a bottle too. Mother has "beaten the life out of her to eat".

Mother was seen for a period of five months at which time the simple principles of mental hygiene were outlined and some positive suggestions were given. During this time mother revealed that she never really cared for children. Mother was unable to accept interpretation and could not change her attitude toward Janet. At last interview she expressed a desire to place Janet. The child's condition was unimproved at time case was closed.

This child has completely dominated the household by her temper tantrums and eating habits until the arrival of sibling. Mother's severe punishment is an overt action of hostility. Her overprotection and over solicitious attitude is compensation for guilt feelings of rejection of Janet. Her fear of Janet's catching a germ may be an unconscious aggressive wish. In her desire to place Janet mother is overtly expressing her rejection.

Janet was badly spoiled during most of her life. She strongly resents her brother and is extremely jealous of him. She has shown her jealousy by being more demanding of her mother and by her resentment toward her cousin when they are with her brother. Janet wishes to revert back to babyhood and dependency when she demands the bottle again. Weaning herself

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may be the child's reaction to mother's unwholesome attitude. Her food fussiness has been aggravated by the arrival of sibling and she is using this area to control mother.

Janet's ability to play with other children outside the home clearly indicates that she is not under tension when away from mother.

Case 4. SARA

Sara, age four, and an only child, was referred by a public health nurse because of poor appetite. She refuses to swallow food, gags and vomits. She shows no interest in food and when left alone plays with the food and throws it on the floor. Mother has forced her to eat by spanking, siting her in a corner with her head faced to the wall and threatening to send her away.

Clinic examination revealed other problems such as enuresis, temper tantrums, jealousy and stubbornness. She is petulant and demanding, has a deathly fear of punishment and doesn't like to be hit. She craves affection. At clinic Sara clings to mother and refuses to leave her. It was observed by worker that mother has punished Sara harshly, would push her away and say she didn't love her any more if she refused to do what mother asked. When with mother Sara cries, whines, and fusses but when away from mother she is "like a different child". She laughs, is agreeable and friendly. Sara is left-handed and mother has been trying to convert her but stopped on the advice of the psychiatrist.

Mother was well and extremely happy during pregnancy. It was a normal birth. Sara was breast fed for only a few days as mother became ill when she returned home. She was weaned from the bottle at six months and has been an eating problem since.

Mother describes herself as a "nervous wreck" and ill, and says she "will never have any more children, I hope". Complains of migraine headaches. She speaks with great emotion about her marriage, which is a failure. In speaking of marital difficulties she rarely could keep back the tears. Mother has never been happy with father as he gambles, is not a good provider and is irresponsible. She had Sara in the hopes that he would settle down but this has not affected any change in his behavior, and now, mother regrets having Sara. Father indulges Sara and does not permit mother to punish her when he is home. He also refuses

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Clinic examination revealed other problems such as enuresis, temper tantrums, jealousy and stubbornness. She is petulant and demanding, has a dreadful fear of punishment and doesn't like to be hit. She craves affection. At clinic Sara clings to mother and refuses to leave her. It was observed by worker that mother has punished Sara harshly, would push her away and say she didn't love her any more if she refused to do what mother asked. When with mother Sara cries, whines, and fusses but when away from mother she is "like a different child". She laughs, is agreeable and friendly. Sara is left-handed and mother has been trying to convert her but stopped on the advice of the psychiatrist.

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to permit Sara to attend a nursery school.

At time of referral family was living with paternal grandparents for economic reasons. They also indulged Sara and mother resented their interference in her relationship with father and her attempt to discipline the child. However, she felt they were kind to her in permitting them to live in their home.

Mother was seen at clinic for five months during which time she resisted treatment. She accepted fairly well interpretation on an intellectual level and suggestions on how to manage Sara but she was not able to apply these suggestions because of her emotional attitudes. When the interviews turned to her relationship between herself and husband and her own family she stopped giving as an excuse that she could not get away.

This child is the product of an unhappy marriage, living in a household where there is much emotional stress and strain. Sara is thoroughly and consciously rejected by her mother. This is clearly demonstrated when mother says she had the child in the hopes of preserving her marriage, but Sara proved a failure. Mother's hostility toward Sara is overtly expressed in her methods of feeding and severe punishment. Her rejection is clearly indicated in her threats to send the child away and may be an unconscious wish. Mother's migraine headaches gives evidence of an emotionally disturbed personality. Her feelings towards paternal grandparents are somewhat ambivalent. On the one hand she resents them because of their interference in her marriage and blames them for father's behavior, on the other hand she feels they have been very good to her financially.

Father's indulgence and refusal to send Sara to a nursery school are symptoms of compensation for his feelings of guilt because of rejection on a more unconscious level.

Sara is an emotionally disturbed youngster whose aggressive behavior suggests insecurity. This behavior is a protest against the faulty parent-child relationship. She is showing the typical reactions to the environmental factors and maternal rejection by grasping any conduct or situation, in this case the eating area, which will give her attention and satisfaction she craves and needs.

In the four cases cited the underlying cause of the eating difficulty is clearly seen in the maternal approach toward feeding. Forced feeding, physical punishment, nagging and threatening are punitive methods and are suggestive of aggression and hostility on the part of the mother. These mothers used their children as outlets for their own frustrations.

All of these children, of preschool age, present behavior problems in addition to the eating difficulty. They are insecure and suffer from lack of affection and acceptance. These children have seized upon the eating area as a means of dominating the mother or as a protest against the faulty mother-child relationship.

Poor Home Conditions and Poor Relationships

Case 5. NICKY

> Nicky, a handsome, quiet, dignified boy of eight was referred for food capriciousness at home by the school principal. He has finicky food habits, will only eat certain foods prepared in a certain way, dislikes milk, will not eat any food that is boiled and refuses to eat raw vegetables. Nicky has been a "small eater since he was born." Mother has always fed him. Even now she coaxes, nags and threatens to get him to eat. Mother has always catered to his whims. Sometimes he can sit at the table through an entire meal without eating any food and without saying a word. Mother is frantic as she fears he will become ill and die because he eats so little.

Nicky is given to considerable day dreaming, he is temperamental, sensitive, morbid, resorts to fits of weeping when he cannot get his own way and will not obey anyone but his mother. He is a good student, well liked by the other children although mother does not permit him to play with boys as "they are too rough".

Mother was very ill and depressed throughout the pregnancy as father died suddenly four months before Nicky was born. The birth was normal and Nicky was not breast fed. He was weaned from the bottle at about a year and from then on was a feeding problem. When a year old Nicky had a convulsion and mother slapped him to bring him out of it and dislocated a vertebra. Mother bound up the child's lower chest and abdomen and kept it that way for a short time and he was all right. More recently, on his eighth birthday, mother gave him Castoria which made him vomit and violently ill. Mother thought he was ill and repeated the dose only to have him vomit again. She repeated the dose until the child finished the bottle. Later mother heard that the Castoria was recalled as there was something wrong with the formula.

This marriage was opposed by both families as father was much older than mother and it was his second marriage. Father was well-to-do and for five years there was constant court litigation over the inheritance. Mother feels she and Nicky have been cheated out of a large sum of money and both are very bitter against father's family. Nicky has a melancholy devotion to his father and can sit for hours at a time staring at his pictures, although he never refers to him verbally. He is extremely jealous of mother and if he sees her going out with a man he does not speak to her for days. His favorite form of retaliation is to remain silent for days when mother has denied him something he wants or reprimmands him. He has been known to lie down on his bed and stare into space in a rigid fashion for hours at a time.

Mother and son have been living with two maternal aunts and several maternal uncles. Nicky pays no attention to any other adult member of the family except mother. These relatives have interfered with discipline and have pampered him until the arrival of a new baby who supplanted him as the center of attention.

Both mother and son were seen once a week for eight months, during which time both received intensive psychotherapy. Nicky also attended the Hobby class and did quite well. Mother was able to accept some interpretation and the

situation was relieved somewhat. At the time of closing Nicky's anxiety state was relieved so that mother herself indicated she wished no further service.

This is a posthumous child of a marriage broken after five months by the sudden death of father. Although it is a home of good economic and cultural background there are copious factors and environmental influences operating against this boy's good adjustment plus the fact that he has certain fundamental personality traits of significance. Mother's attitude toward the boy, which is overprotective and oversolicitous, is a result of feelings of guilt about the marriage and unconscious rejection of the child. A more recent basis for guilt is the fact that she believes she fractured his spine and then poisoned him over a long period of time with Castoria. Mother resents Nicky who is interfering with her chances for a second marriage. This also gives rise to feelings of guilt and she permits him to dominate and possess her in obvious fashion.

Nicky reveals an emotionally disturbed, maladjusted, insecure youngster with a question of depressions. There is a question as to how genuine these depressions are and there is a need for further study. This boy is using the eating difficulty as a means of punishing mother and controlling her. His silent spells are another method of punishment. He gloats and takes delight in excercising this power. Nicky's personality difficulties are a direct result of irremedial factors in the home and the unconscious rejection on mother's part are understandable in view of the circumstances and the boy's attitude which is brooding and morbid.

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Case 6. JOSEPH

Joseph, a boy of superior intelligence, was referred by his mother at the age of eight because of food capriciousness and poor eating habits. He is very "picky" and if there is one thing on his plate he doesn't like he will refuse the entire meal. Sometimes he waits until the family has finished and then will eat his meal. Other times he justs sits and "dreams" at the table. He refuses bread and vegetables and is always complaining about the menu. At the table he is slow and dawdles with his food.

Joseph revealed other problems such as day dreaming, negativism, and poor school work. In describing Joseph, mother speaks without emotion and says "he is anti-everything and takes the opposite side just to be different". There is also some enuresis.

This is an only boy and a middle child. The oldest is eleven and the youngest is five years old. He was a wanted child. Mother was in fair health during pregnancy and it was a normal birth. He was breast fed for three months and weaned from the bottle at fifteen months. There was no apparent reaction. His food capriciousness dates back about two years. Joseph shows marked jealousy of younger sibling and does not want to play with her; at the same time he does not permit her to play with anyone else. He threatens her playmates by throwing rocks at them. He does not get along with the oldest sibling and is constantly at odds with her. This sibling is dogmatic and domineering. The younger sister is vivacious and the exact opposite of Joseph.

Mother told worker Joseph reminded her a good deal of maternal grandfather whom she described as a "disagreeable man" and who was the cause of her having a nervous breakdown. After the birth of Joseph mother had another "breakdown" and was ill for four months. He was breast fed for a short time and weaned from the bottle at one year with no difficulty.

At the present time mother has "nervous spells" and has "funny feelings". Mother fears perhaps Joseph is ill too. A medical examination revealed that he was low in hemoglobin and although medicine was prescribed mother did not buy it.

Joseph is in the fourth grade. The teacher revealed that he is slow, has poor coordination between "hand and mind", day dreams and has the handwriting of an old man. Mother expressed the feeling that "he is just plain dumb".

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During the ten-month period of treatment mother revealed that father was working hard, was losing weight and becoming increasingly irritable. His physician recommended that he consult a psychiatrist. At the suggestion of the clinic psychiatrist Joseph was placed in the third grade where he made a very good adjustment and did the work commensurate with his ability. He attended the Hobby class and profited a good deal from this experience. It was observed by worker that Joseph was not the same boy as outside while in the class. He enjoyed making things and worked hard, using considerable energy. Mother was unable to carry out even the simple principles of mental hygiene and during the last few months she did not receive any treatment but merely waited for Joseph.

Joseph is an immature, insecure little boy who is in a difficult position in the family. He is a middle child. He is unable to keep pace with the older sibling and cannot keep ahead of the younger one and is, therefore, attempting to be opposite in all ways in order to gain the attention he wants. His school experience was not a satisfying one as he was overplaced and, as a result, his school work was poor. Once in his right element the tension was relieved and his school work improved.

Mother unconsciously rejects this boy as she identifies him with maternal grandfather toward whom she has so much antagonism. Her fears for Joseph's health and her inability to carry through with the physician's suggestion to provide medicine to rebuild the hemoglobin deficiency may be an unconscious aggressive wish. Both parents are seriously maladjusted individuals who are incapable of giving Joseph the warmth and affection he needs.

Joseph's eating habits and capriciousness are attempts to gain attention and are also a means of displaying hostility towards the mother whose rejection he feels. The Hobby class enabled him to work off some of his aggressive feelings.

During the ten-month period of treatment mother revealed that father was working hard, was losing weight and becoming increasingly irritable. His physician recommended that he consult a psychiatrist. At the suggestion of the clinic psychiatrist Joseph was placed in the third grade where he made a very good adjustment and did the work commensurate with his ability. He attended the Hobby class and profited a good deal from this experience. It was observed by worker that Joseph was not the same boy as outside while in the class. He enjoyed making things and worked hard, using considerable energy. Mother was unable to carry out even the simple principles of mental hygiene and during the last few months she did not receive any treatment but merely waited for Joseph.

Joseph is an immature, insecure little boy who is in a difficult position in the family. He is a middle child. He is unable to keep pace with the older sibling and cannot keep ahead of the younger one and is, therefore, attempting to be opposite in all ways in order to gain the attention he wants. His school experience was not a satisfying one as he was overplaced and, as a result, his school work was poor. Once in his right element the tension was relieved and his school work improved.

Mother unconsciously rejects this boy as she identifies him with maternal grandfather toward whom she has so much ambivalence. Her fears for Joseph's health and her inability to carry through with the physician's suggestion to provide medicine to rebuild the hemoglobin deficiency may be an unconscious aggressive wish. Both parents are seriously maladjusted individuals who are incapable of giving Joseph the warmth and affection he needs.

Joseph's eating habits and capriciousness are attempts to gain attention and are also a means of displaying hostility towards the mother whose rejection he feels. The Hobby class enabled him to work off some of his aggressive feelings.

Case 7. NANCY

Nancy, age six, the third of four children, was referred by a hospital because of severe eating difficulties. She will not eat cereal, egg, vegetables or meat and will not drink milk. The only vegetable she eats without protest is lettuce. Mother coaxes and cajoles and Nancy will eat only if mother watches her. Nancy keeps running in between meals for cookies, candy and fruit and she will scream and have a temper tantrum if mother refuses, so generally she gives in to her. Other problem revealed is diurnal enuresis. When she wets she feels ashamed and either hides or puts herself to bed.

According to mother, Nancy has an "awfully mean disposition, is cranky and is as fresh as she can be". She upsets mother by saying to her "oh you rat!" For not eating, mother makes her stand in the corner with her head facing the wall or she is spanked. Nancy gets along well in school and with other children. It is only at home that she displays a severe temper and fights with other siblings. She is especially jealous of the youngest, a boy who is sickly with a probable diagnosis of mentally deficient and who has received a good deal of attention from mother. Nancy has accused mother of not loving her.

Nancy is the child of a forced marriage. Mother, a Catholic, had been living with father, Protestant, and divorced for a long time. When she became pregnant she forced father to divorce his wife and marry her. Father is alcoholic, a poor provider and extremely brutal. There is constant quarrelling and father is continually reminding mother of indiscretions.

Mother was very ill during pregnancy and attempted an abortion. Nancy was not breast fed and she did not thrive on the bottle. She was weaned at nine months. Nancy has always been a feeding problem.

This case was known to clinic for six months during which time very little could be done for Nancy as mother did not carry through with any of the suggestions, was unable to accept any interpretation and she used the clinic as a threat to her. Psychiatric interviews with mother revealed that she feared the youngest child's condition was caused by the attempted abortion. She was also concerned because she could not receive the full sacraments of the church and "it preyed" on her mind. It also became known that father preferred older siblings to Nancy.

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Nancy is the product of a home where there is constant marital discord. Father, an alcoholic, is a weak, unstable individual with many emotional problems of his own. Nancy is rejected by both parents and is deprived of all attention. She is jealous of younger brother because he is favored by mother and of older siblings because they are preferred by father. Mother has shown marked overt hostility toward Nancy in methods of feeding and punishment. Nancy is retaliating in like manner by calling mother "rat" and by her eating habits which are aggressive. Her enuresis is an expression of hostility toward mother and jealousy of siblings. This hostility is accompanied with guilt with the consequent result of self-punishment.

Mother is an unstable woman under severe emotional strain because of her marriage which is not recognized by the church, because of the forced marriage and because of her attempted abortions. Father keeps these feelings alive by his constant reminder of her indiscretions. As a result mother is overwhelmed with feelings of guilt.

Nancy's symptoms indicate lack of affection and security and very few satisfactions. Her behavior is an outgrowth of an unsatisfactory home situation which is marked by insecurity and continued emotional tension. It is a direct result of poor relationships and maladjusted parents.

Case 8. SUSAN

Susan, an eight-year-old, colorless little girl, was referred for food fussiness by a Family Service. She has not eaten well since weaned and has always been a small eater. For breakfast she will only have milk, will not eat lunch in school but is very fussy about supper. She refuses vegetables, except tomato, will not eat meat or bacon. Susan watches mother

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prepare the meal and if it is not prepared the way she wants it she refuses to eat. Father insists that mother feed her when she refuses to eat. To avoid arguments mother has done this many times. On other occasions father has threatened to kill her and has inflicted severe physical punishment when she refused to eat. Susan has been taken to many physicians but "they can't get her to eat".

Although somewhat timid Susan has a good disposition, is a good student and gets along fairly well with other children. However, she refuses to attend school.

Susan is the youngest of three children. The two older boys, ages twenty-four and twenty-one, are living out of the home and are not interested in her. Mother was well during pregnancy although under considerable economic stress as father was unemployed. Susan was not breast fed as mother had insufficient milk and was weaned from bottle at two years. Between the ages of three months and four years Susan lived with maternal grandmother to enable parents to work. She has been ill with bronchitis and a kidney ailment since infancy and she also has had "upset nerves" manifested by spells during which she "banged on the table and hollered". At five, family physician told mother child was on the verge of a nervous breakdown. Susan is always remarking that her parents do not love her.

There is constant quarreling in the home as parents do not agree about discipline. Interviews also revealed that father is stubborn, cruel, abusive and promiscuous with other women. Susan is aware of this as she made several references about it to psychiatrist. Father feels Susan is "just as stupid as mother". Mother is submissive and has given in to father because of his violent temper.

The psychiatrist and social worker saw both parents and child for a period of fifteen months. During treatment parental attitudes were discussed, the meaning of the eating difficulty to the child was explained and although both parents were considered poor material they responded fairly well. At time of closing Susan's eating habits had improved, she no longer had temper tantrums and she was attending school without protest.

This child is the offspring of parents with limited mental capacity. Born to parents in later life she is obviously rejected by both of them. Father's hostility is clearly shown in his manner of approach to the feed-

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ing problem and his aggression is evident in the corporal punishment inflicted on Susan and in his threat to kill her. His overprotective attitude which is compensation for guilt feelings is shown in his concern over the eating problem. He has displaced some of his rejection of mother onto Susan whom he identifies with mother. He may also be using her as an outlet for his own frustrations and deprivations. Mother is an ineffectual woman who apparently has very little influence in the family.

Susan is an emotionally unstable, undisciplined, insecure child, the product of poor upbringing and poor home environment. She has seized upon every means such as eating and temper tantrums to gain her own way. She displays hostility and aggression towards parents by temper tantrums and eating behavior. Susan's refusal to go to school is indicative of her dependence and lack of security. Her poor home background may have seriously hampered her ability to form the proper identifications.

It is obvious, however, that the main difficulty lies in the parents' inability to handle their social role of parenthood in a calm, intelligent and constructive way. This in turn is no doubt due to their own background, relationships to their own parents and the many frustrations and deprivations they have experienced.

Case 9. LOUISE

> Louise, a solemn child of superior intelligence was referred at the age of ten because of extreme food fussiness by the family physician. According to mother food must be prepared in a certain manner and she will only eat bananas and cream or strawberries. After considerable coaxing and cajoling she may drink milk. She refuses to eat eggs or vegetables and will eat potatoes only if they are fried. Lately she has refused to eat canned fish for fear of being poisoned.

She eats minute quantities of food for fear of dying from overeating and after every meal she must take baking soda for "relief" then says, "now I won't die, will I mother"? She has difficulty in swallowing at times and occasionally she gags and vomits. Mother has threatened to send her away if she does not eat. Psychiatric examination revealed additional problems such as enuresis, nervousness and refusal to attend school.

Parents were married for fourteen years before Louise was born. Mother had two miscarriages during first two years of marriage. Mother was nauseated during entire pregnancy. During confinement there was an epidemic of enteritis in the hospital nursery affecting fourteen babies of which nine died and "she had to be saved". Louise was never breast fed but was bottle fed for one year. It seems she was always a poor and finicky eater. Mother has also been a poor and finicky eater and when a child was treated at the Habit Clinic for the same complaint.

A maternal aunt, who was ill with a thyroid disturbance and a cripple has always lived with this family. Father, a war veteran, died the previous year of heart trouble after a long illness. He was bedridden for two years and mother spent all her time caring for him while aunt cared for Louise. Louise was resentful of attention given to father and refused to go into the room to see him. She was "glad God took him" when he died. She has accused mother many times of not loving her. When aunt died suddenly a few months after father Louise was bitter and expressed a wish that it might have been mother instead of aunt. She distresses mother by telling "tall stories" about her to friends and relatives and does all sorts of things to embarrass her. Louise pinches mother when she doesn't give in to her wishes. Both mother and daughter worry about each other's health and Louise will not permit mother to go anywhere without her. Mother is solicitous about child's health and is constantly asking her how she feels. Both have complained of many of the symptoms father and aunt had such as difficulty in swallowing, smothering spells, pains and headaches.

Louise was seen by the psychiatrist once a week for eight months during which time she received intensive psychotherapy. These interviews revealed that she talks and laughs in her sleep. She had several dreams where her deceased aunt appeared telling her to be a good girl and be good to her mother. She was given an opportunity to verbalize her feelinga about mother, father and aunt. At the end of treatment

she had improved considerably, was doing well in school and her eating habits had improved somewhat. After the third clinic visit mother refused to come and merely brought Louise to clinic.

This is a neurotic child of a neurotic mother. Both have patterned their neuroses upon the ailments of the father and aunt. Louise has suffered severe trauma at the hands of this neurotic and rejecting mother. This rejection is obvious in mother's statement to worker that "she had to be saved".

Louise is an insecure child who has absorbed much of her mother's anxiety. Her behavior in the eating area is geared to attention getting and is a means of dominating and punishing mother. It may also be a strong identification with mother who is also a finicky eater. By her refusal to attend school Louise desires to remain dependent upon mother. Her dreams indicate she must have tremendous guilt feelings.

Although Louise had improved somewhat at time case was closed it was felt that she and mother needed more psychiatric study. She had lost her fears about food and she did not dream. Mother's inability to form a relationship with the worker suggests that the clinic was a threat to her.

Case 10. RICHARD

Richard, a four-and-a-half-year-old colorless youngster was referred for capricious eating habits by paternal grandmother. He will eat solid foods only under duress but will drink more than a quart of milk a day if permitted. He is indifferent to food. When he does consent to eat after considerable coaxing and nagging he dawdles and plays with his food and it "takes him hours to finish a meal". Mother is also a fussy eater and does not eat many foods. If mother refuses certain food Richard will also.

Case 10. RICHARD

Richard is described as babyish with infantile speech, he bites his nails, resorts to temper tantrums and is disobedient to parents. He does not get along well with older sibling, a girl, and has shown marked hostility to his younger brother who is taller, stronger and the more aggressive. He is constantly seeking approval from mother. Shortly after the birth of younger sibling who is now three he began to wet again. Although he gets along with other children mother does not permit him to play outside as she fears he will be hurt.

Mother was in good health during pregnancy although she attempted an abortion. Birth was normal and Richard was breast fed for only four weeks as mother had insufficient milk. He was weaned from the bottle at one year but it wasn't until youngest sibling was born that he showed any food fussiness. Father toilet trained Richard at an early age and was extremely strict. Mother is always comparing Richard unfavorably with younger sibling.

Mother lived with father for several months before marriage. She is a quiet, gentle ineffectual woman who is somewhat overwhelmed with the many problems she has confronting her. Father is described as abusive, evasive, unstable with a poor social and emotional background. A local hospital diagnosed him as psychoneurotic. Father says Richard is just like his mother and her family who "are all crazy". There is marked hostility between the two families and paternal grandmother is constantly interfering in the home.

Richard was seen by the psychiatrist for a period of eight months and was also given speech therapy. Very little could be done with mother as she shyed away from discussing relationship between herself and Richard was reluctant to talk about the home situation or family. Richard's speech improved but the eating problem remained unimproved.

Richard's behavior and neurotic habits are the result of emotional insecurity and sibling rivalry. He is regressing to infantile behavior when he refuses to eat solid food but is willing to drink a quart of milk a day. Richard was only a baby for a short time having to give way to his younger brother who has dethroned him in position of favor. He is not a wanted child and mother has expressed her feelings by comparing him unfavorably with younger sibling who is stronger and more

aggressive. In his eating habits Richard identifies with mother and is also using it as a device to gain attention which he otherwise does not have. In Richard's early and strict toilet training father has also been rejecting and shown hostility.

This is the middle child of an unstable father and ineffectual mother. He has been reared in an atmosphere of financial need and domestic quarreling. Training has been lax and inconsistent, with interference by relatives. Reversion to enuresis is an expression of hostility to mother and jealousy of sibling. In identifying Richard with mother and intimating that her family is "crazy" father is also rejecting mother. Richard is an immature child whose eating behavior is a direct result of his deprivation and lack of affection.

In the foregoing cases the poor home conditions and poor relationships were the largest contributing factor towards the maladjustment of the child. Rejection, overprotection, marital discord, sibling rivalry, ineffectual parents and interference of collateral relatives are clearly in evidence. Eating difficulties of such severity as to be brought to the attention of a psychiatric clinic are an indication of tension which may be due to general anxiety and insecurity. The eating disturbance was indicative of the emotional instability of the child and his environment.

CHAPTER VIII

SUMMARY AND CONCLUSIONS

In this thesis the writer has endeavored to study the causative factors influential in the eating difficulties of children. Of the ninety-three cases referred to the Massachusetts Child Guidance Clinics from the calendar years of January 1, 1941 to December 31, 1944 because of an eating problem only twenty-nine cases were selected on the basis of the following criteria:

1. Cases in which the eating difficulty was the primary complaint.
2. Cases with full data which included the reports of the psychiatrist, psychologist and social worker.
3. Cases in which the child was living within his own family group.

Analysis of general information revealed that there was practically an equal number of boys and girls, more than one-half being of pre-school age, the others ranging in age up to eleven years. The majority were of average or better than average intelligence with only five in the dull normal group. There were eleven only children. There was a variety of nationalities and religions represented but there were no indications that these factors were of significance in relation to the eating problem. The children as a whole had periods of illnesses but they did not appear to be directly related to the eating disturbances. On the whole, the group seemed to be well nourished and in good health during the entire clinic contact. The study group was a good cross-section of the middle class and the economic status ranged from high to marginal income.

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Sources of referral revealed that twenty children were referred by either a local physician or a hospital. These mothers turned to a physician for advice on child training and they also felt that the eating difficulties were of physical origin. In the cases studied the mothers were either unable or refused to accept the fact that the eating difficulties had an emotional basis. In twelve cases the child lived within a complex family situation due to the presence of collateral members. This created problems in adjustment.

The majority of the children presented a variety of behavior and personality problems in addition to the eating difficulties. These ranged from symptoms of an emotional nature; such as, tics, enuresis and thumbsucking to general personality problems that suggested disturbances in the sphere of social adaptation. The personalities of the study group were described as either aggressive, passive or normal and there was no indication that their type of personality was influential in the pattern of the children's eating behavior. All three groups manifested aggressive behavior in the eating area. At mealtimes there appeared no differentiation in aggressive behavior patterns of all three types of personalities.

In studying these cases the writer found that the underlying cause of the eating difficulties was for the most part due to the child's lack of emotional security and affection. Most of the cases gave evidence of parental rejection especially faulty mother-child relationship and strong rivalry between siblings. The family is the most important environmental factor in changing the child from an asocial to a social individual.

The family frames of these children revealed that poor home conditions and poor relationships were the largest contributors to their eating difficulties. The marital adjustment in the majority of cases was poor because the parents were inadequate and immature individuals. Parental disharmony, sibling rivalry, ineffectual parents and interference of relatives caused tension, friction and insecurity which was reflected in the children's eating habits.

The incidence of maternal rejection was high. While some mothers openly admitted the child was not wanted, in many cases this was veiled by overprotection and overindulgence. Rejection is clearly seen in the hostile and punitive approaches toward feeding, and in the short duration of the breast feeding period, in more than one-half as little as two months. Thus, by far, a large majority of mothers deprived their children of the normal satisfactions of breast feeding. Levy has pointed out that there is a tendency on the part of rejecting mothers to oppose breast feeding or to shorten the nursing period.[1] There was lack of material with reference to the problems and methods of weaning. It should be emphasized, however, that not all mothers who show anxiety about a child's food intake are consciously or unconsciously rejecting their offspring. Although there is little evidence in this case study, it is true that many mothers show concern about food refusal where there is a warm and wholesome tie between mother and child. The rigid standards set up during the years regarding food intake and nutrition are in some measure a cause of this anxiety.

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1. Dominate the mother
2. Gain the attention they ordinarily did not enjoy.
3. Punish mother for frustrations and deprivations
4. Maintain their dependency
5. Protest against the emotional turmoil of their environment

Maternal attitudes were of paramount importance in influencing the development of the children's own personalities and social relationships. These children were emotionally insecure individuals using the eating situation as a method of indicating dissatisfaction.

Treatment revealed that when the tension was removed somewhat the children responded. However, in most cases the mothers were resistive and unable or unwilling to make any change in their attitudes. When confronted with a discussion of their own relationship with the child or with their families they considered the clinic a threat and terminated contact. Because of the small number of cases and the paucity of information regarding parents' backgrounds and relationships with their own families it is impossible to draw further conclusions.

Approved,

Richard K. Conant

Richard K. Conant, Dean

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Approved,

Edward K. Cornell, Dean

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APPENDIX

Schedule

Name Number Clinic

Birthdate

Sex

Nationality

Religion

Intelligence Quotient

Health

Ordinal position

School grade

Additional problems as revealed

Eating difficulty
Duration

Methods of feeding

Maternal attitudes toward pregnancy and breast feeding

Personality factors

Family history
Paternal
Maternal
Relationships within the home
Collateral relatives living in the home
Marital situation
Economic situation

Treatment

Analysis

APPENDIX

Schedule

Name Number Child's

Birthdate

Sex

Nationality

Religion

Intelligence Quotient

Health

Ordinal position

School grade

Additional problems as revealed

Testing difficulty
Duration

Methods of feeding

Maternal attitudes toward pregnancy and breast feeding

Personality Factors

Family history
Paternal
Maternal
Relationships within the home
Collateral relatives living in the home
Marital situation
Economic situation

Treatment

Analysis